

**Commonwealth of Kentucky
Personnel Cabinet
Department for Employee Insurance**

Dependent Drop Form

This form must be used for any qualifying event (QE) that allows you to drop dependents from your plan. You must complete a health Insurance application to request other coverage election changes such as moving out of the service area.

Applicant's SSN

Retiree's SSN (if applicable)

Company Number

Name (First, MI, Last) _____
(PRINT)

Date of Birth (MM/DD/YYYY) _____

To be eligible to drop a dependent from your health insurance plan, you must certify that you have experienced the QE as listed below. By signing this form you are also certifying that you are not under any court order or administrative order to cover the dependent(s) on your health insurance plan.

The QEs listed on this form are the only events that allow you to drop dependents from your plan. **(Check One)**

- | | |
|--|--|
| <input type="checkbox"/> Marriage
<input type="checkbox"/> Divorce*/Legal Separation*/Annulment*
<input type="checkbox"/> Spouse/Dependent/Retiree's Death
<input type="checkbox"/> Administrative Order* or Court Order*
<input type="checkbox"/> Dependent child becomes ineligible
<input type="checkbox"/> Spouse/Dependent gains employer-sponsored group coverage | <input type="checkbox"/> Spouse/Dependent ends LWOP
<input type="checkbox"/> Employee/Spouse/Dependent becomes eligible for Medicare*
<input type="checkbox"/> Employee/Spouse/Dependent becomes eligible for Medicaid*
<input type="checkbox"/> Spouse/Retiree has different open enrollment period*
<input type="checkbox"/> Significant cost increase (<i>Dependent Care changes ONLY</i>)
<input type="checkbox"/> Other: _____ |
|--|--|

Qualifying Event Date (MM/DD/YY): _____

** Supporting documentation is required.*

PRINT the following information for each person to be dropped: (If you wish to drop coverage for yourself, you must also include your name in the table below)

Social Security Number	Name (First, MI, Last)	Relationship Code **

** Relationship Code: SP=Spouse CH=Child DD=Disabled Dependent CO=Court Ordered Dependent SELF=To terminate coverage for yourself

Applicable to employees of State Agencies ONLY (Commonwealth Choice). All other employees must contact their Insurance Coordinator for specific information about the employer's Flexible Spending Account Program. Retirees are not eligible to participate in an FSA.

Healthcare Spending Account

I request a change in my "per check" deduction

from \$ _____ to \$ _____ employee money

from \$ _____ to \$ _____ employer money

Dependent Care Account

I request a change in my "per check" deduction

from \$ _____ to \$ _____ employee money

My signature below certifies that I understand the statements on this form and that all the information provided by me is true and complete to the best of my knowledge. I understand that any person who knowingly and with intent to defraud any insurance company or other person, files this form containing any materially false information or conceals, with the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. I understand that any material misrepresentation or material omission contained herein may be used to void this contract.

Applicant Signature

Date

Insurance Coordinator Signature

Date

Retiree Signature

Date

The following signatures are REQUIRED if changes to a cross-reference payment option are being requested.

Spouse Signature

Date

Spouse's Insurance Coordinator Signature

Date